

FILED FEB 26 1949

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 4944

Registrar's No. 518

|   |                               |   |  |   |  |   |  |
|---|-------------------------------|---|--|---|--|---|--|
| BIRTH NO. _____   |                               | REG. DIST. NO. <u>149</u>   |  | PRIMARY REG. DIST. NO. <u>1002</u>  |  | Registrar's No. <u>518</u>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>   |                               |   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>   |  |   |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Little Sisters of the Poor</u>  |                               |   |  | d. STREET ADDRESS (If rural, give location) <u>5331 Highland</u>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>M James</u>  |                               | b. (Middle) _____   |  | c. (Last) <u>Hogan</u>  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 3, 1949</u>                                 |  |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>  |  | 8. DATE OF BIRTH <u>5/26/1862</u>   |  | 9. AGE (In years last birthday) <u>86</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY _____   |  | 11. BIRTHPLACE (State or foreign country) <u>Ireland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13a. FATHER'S NAME <u>Dennis Hogan</u>  |                               | 13b. MOTHER'S MAIDEN NAME <u>Anna Keating</u>   |  | 14. NAME OF HUSBAND OR WIFE _____   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>NONE</u>   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Sister Emilee 5331 Highland</u>  |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.   |                               | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Thrombosis</u><br><br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertensive Heart Disease</u><br>DUE TO (c) <u>Generalized Arterio-sclerosis</u><br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>420.1</u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>12 Hours</u><br><u>16 years</u><br><u>20 years</u> |  |
| 19a. DATE OF OPERATION<br>* _____   |                               | 19b. MAJOR FINDINGS OF OPERATION _____  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____  |                               | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____  |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____   |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.  |                               | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21f. HOW DID INJURY OCCUR? _____  |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>Sept. 1948</u> , 19 <u>21</u> , to <u>2/3/49</u> , 19 _____, that I last saw the deceased alive on <u>2/3/49</u> , 19 _____, and that death occurred at <u>5:00 A. m.</u> , from the causes and on the date stated above. |                               |   |  |   |  |   |  |
| 23a. SIGNATURE <u>John T. Skinner</u>   |                               | 23b. ADDRESS <u>Skinner m.d. 1402 Brimley Bldg.</u>   |  | 23c. DATE SIGNED <u>2/4/49</u>  |  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>   |                               | 24b. DATE <u>2/7/49</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>  |  | 24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>                |  |
| DATE REC'D BY LOCAL REG. <u>2-4-49</u>  |                               | REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Shirley</u>   |  | ADDRESS <u>20 West Linwood</u>  |  |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or ~~by~~ \_\_\_\_\_

\_\_\_\_\_, Student Embalmer No. \_\_\_\_\_,  
working under my personal supervision.

Signed \_\_\_\_\_  
Student Embalmer

Signed Howard W. Farmer

Licensed Embalmer No. 4134

P. O. Address Kansas City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.